S # 20 9

	NT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DAT	APPROV 0. 0938-0 TE SURVEY MPLETED
4445		445457	B. WING			
NAME OF	PROVIDER OR SUPPLIER		1	STOCET APPROPRIA	08/	28/2013
EAST T	ENNESSEE HEALTH C	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 485 ISBILL RD		
(X4) ID PREFIX	SUMMARY STAT	TEMENT OF DEFICIENCIES	ID ID	MADISONVILLE, TN 37354		
TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERCIENCY)	D. D.C.	COMPLET DATE
F 000	INITIAL COMMENT:	s	F 00	0	<del></del>	<del></del>
	conducted on August Tennessee Health Co cited under 42 CFR	ation survey and complaint ers 31633, 30665, 31635) t 26-28, 2013, at East are, no deficiencies were PART 483.13, Requirements related to the complaint				
ין ע≃סט ו	183.12(a)(3) DOCUMI FRANSFER/DISCHAF	RGE OF RES	F 202	F202	.,	
ir	r paragraph (B)(2)(I) (I Te resident's clinical m	he circumstances specified		483.12 (a) (3) Documentation for Transfer/Discharge of Res	)T	
d	y me resident's physic ischarge is necessary	Cian when transfer or		SS=D <u>Requirement:</u>		
9	r paragreph (a)(2)(ii) ( hysician when transfe nder paragraph (a)(2)	r of discharge is necessary		When the facility transfers of discharges a resident under and of		
by	<i>f</i> :	is not met as evidenced		the circumstances specified i paragraph (a) (2) (i) through (v) of	n	
E th	ased on medical reco e facility failed to ensu	ord review and interview ure the discharge		this section, the resident's clinical record must be documented. The	1	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued regram participation.

ORM CMS-2567(02-99) Previous Versions Obsplete

Event ID: 813311

Facility ID: TN6201

If continuation sheet Page 1 of 31

- OLI	<u>LENO FUR MEDICARI</u>	AND HUMAN SERVICES  & MEDICAID SERVICES			PRINTE	D: 09/04/201
STATE	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER:	V. Brille	LTIPLE CONSTRUCTION DING	OMB N (X3) D	MAPPROVE( O. 0938-039- ATE SURVEY DMPLETED
- NI 105		445457	B. WING			
į	OF PROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE, ZIP CODE	0	3/28/2013
	TENNESSEE HEALTH O			465 ISBILL RD MADISONVILLE, TN 37354		
(X4) I PREF TAG		FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFD TAG	PROVIDER'S PLAN OF CORRECTY	n or	(XS) COMPLETION DATE
F 20		available for two recidents	F 20	documentation must be made by resident's physician when transfe discharge is necessary un	r or ider	
	discharged to home of	v revealed Resident #18 was y on March 14, 2013, and on April 15, 2013.		paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and physician when transfer or dischassis necessary under paragraph (a)(2)(iv) of this section.	la mge	
F 272 SS=D	continued to the facility discharged on April 30 Continued review of the no documentation of a residents #18 and #86 Interview with License August 26, 2013, at 30 confirmed there was a documented for reside 483.20(b)(1) COMPRE	ne medical records revealed a discharge summary for it.  d Practical Nurse #2 on 26 p.m., in the hallway, o discharge summary onts #18 and #28	2	<ol> <li>Staffing Coordination completed DC summary residents #18 and #86 9/10/13.</li> <li>100 % audit of all DC chafrom 1/1/13 through presidented 9/11/13 Staffing Coordinator.</li> <li>ADON In-serviced Staffing Coordinator on 8/26/13 the summary of the staffing Coordinator on 8/26/13 the staffing Coordinator on 8/26/13 the summary of the staffing Coordinator on 8/26/13 the</li></ol>	for on uts ent by	
		comprehensive nt's needs, using the strument (RAI) specified ssment must include at		D.C.	be of	

PRINTED: 09/04/201: FORM APPROVEL OMB NO. 0938-0301

AND DIE	NT OF DEFICIENCIES	(X1) PROMPERMON (CO.)				OMB NO. 0938-03		
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	TIPLE CONSTRUCTION	(X3) I	NO. 0938-039 PATE SURVEY COMPLETED		
NAUE OF	PROVIDER OR SUPPLIER	445457	B. WING		}			
	ENNESSEE HEALTH (	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 466 IBBILL RD		8/28/2013		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<u> </u>	MADISONVILLE, TN 37354				
PREFIX TAG		MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATION	MU	(XG) COMPLETION DATE		
F 272 A. Ti a reful as resiby lead	documentation was (#18, #86) of twenty reviewed.  The findings included Medical record review admitted to the facility discharged to home of the facility discharged on April 30 Continued review of the documentation of a residents #18 and #86 Interview with License august 28, 2013, at 3: onfirmed there was nocumented for reside 83.20(b)(1) COMPRESSESSMENTS  The facility must conduct the facility must make a consessment of a resident assessment in the facility must make a consessment of a resident assessment in the facility must make a consessment of a resident assessment in the facility must make a consessment of a resident assessment in the facility must make a consessment of a resident assessment in the facility must make a consessment of a resident assessment in the facility must make a consessment of a resident assessment in the facility must make a consessment of a resident assessment in the facility must make a consessment of a resident assessment in the facility must make a consessment in the facility must make a consessment of a resident assessment in the facility must make a consessment of a resident assessment in the facility must make a consessment of a resident assessment in the facility must make a consessment of a resident assessment in the facility must make a consessment of a resident assessment	available for two residents discharged residents  d:  w revealed Resident #18 was y on March 14, 2013, and on April 15, 2013.  w revealed Resident #86 was y on April 12, 2013, and 0, 2013.  the medical records revealed a discharge summary for 3.  d Practical Nurse #2 on 26 p.m., in the hallway, on discharge summary ints #18 and #86.  EHENSIVE  act initially and periodically trate, standardized ant of each resident's entry needs, using the strument (RAI) specified assment must include at	5	Administrator/Nurse Management team wil service and co monitoring until subs compliance is achieved	ially sive,	Completed By: 09/20/2013		

PRINTED: 09/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	THE SERVICES		<u></u>	
NO PLAN	OF CORRECTION	(X1) PROVIDER/GUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	OMB NO, 0938-038 (X3) DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER	445457	B. WING		08/28/2013
	ENNESSEE HEALTH C	ARE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RO	1 00/20/20/13
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROFICIENCY)	# Par Profession Company
Ti by B the was contact. The Res	Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special freatments and Discharge potential; Documentation of sun the additional assessmaneas triggered by the Data Set (MDS); and Documentation of particles on medical recommentation of particles and Discharge facility failed to accept the securately assess the bountractures for one residents reviewed.	patterns; ing; and structural problems; and health conditions; istatus; and procedures; and procedures; and performed on the care and performed on the care completion of the Minimum icipation in assessment.  Is not met as evidenced and review and interview, arately assess significant dent (#55), and failed to illateral lower extremity sident (#75) of thirty-one	F 27	1. Resident #55 assessment for 5/2/13 modified on 9/11/12 reflect accurate weigh THM MDS Consu Resident #75 assessment for 5/24/13 modified on 8/27/13 reflect bilateral le extremity functi limitation by M Coordinator. 2. 100 % audit of current M assessment of all reside was completed by 9/16/13 THM MDS Consultant. 3. THM MDS Consultant serviced/educate MI Coordinator/Backup MI Coordinator and all member of Interdisciplinary Tea (IDT) regarding accurate and importance to revie	t by Itant. MDS was to ower onal fDS  DS ents by in- OS OS ex on o o o o o o o o o o o o o o o o o o

PRINTED: 09/04/2013 FORM APPROVED OMB NO. 0938.0301

	STATEME	NT OF DEFICIENCIES	A MEDICAID SERVICES				MRN	10.0938-03	O'
ļ	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILL	iltapi Ding	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		<u> </u>
	NAME OF	PROVIDER OR SUPPLIER	445457	B. WING	B. WING			<b>8/28/20</b> 13	
		ENNESSEE HEALTH C	ARE	į	4	TREET ADDRESS, CITY, STATE, ZIP CODE 85 ISBILL RD MADISONVILLE, TN 37354			
	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X6) COMPLETION DATE	4		
		Deep Vein Thrombood Oropharyngea! Dysp Review of the Admis (MDS) dated April 11 weighed 127 pounds Medical record review Record revealed the 1.) April 4, 2013, Adm 2.) April 15, 2013, 12 percent (%); and 3.) April 22, 2013, 12 admission or 5.5%; a Review of a Registered dated April 24, 2013, referred to RD r/t (related April 24,	sis, Aortic Stenosis, and hagia.  sion Minimum Data Set , 2013, revealed the resident with no weight loss or gain.  In of the Patient Weight following weight in pounds: alt 127.2;  1, a loss of 6 pounds or 4.7  10, a loss of 7 pounds since significant weight loss.  20 Dietitian's (RD) note revealed "Resident ated to) significant weight 127.2# alt 120#"  Prospective Payment ment dated May 2, 2013, weighed 120 pounds with	F 2	72	completed assessments daily M-F in Morning QA for 30 days then weekly for 3 months, then biweekly for 1 month until substantial compliance is achieved. If compliance is not met the Administrator/Nurse Management will re-inservice and continue monitoring until substantial compliance is achieved.		Completed By: 09/20/2013	
	<u>_</u> "		er er skrauterik terrik ter		1		1	1	

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES			,	RINTE	D: 09/04/2013
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES				FOR	M APPROVED
STATEME	NT OF DEFICIENCIES LOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		445457	B. WING	G		'	
NAMEO	PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	/28/2013
EAST	ENNESSEE HEALTH C	ARE		Ŀ	465 ISBILL RD MADISONVILLE, TN 37354		
(X4) ED	SLIMMARY STAT	EMENT OF DEFICIENCIES	ID	1	PROVIDERS PLAN OF CORRECTION		
PREFIX TAG	{EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	RE	COMPLETION DATE
F 279 SS=D	the resident required Activities of Daily Liv functional limitation is side in the lower extra Observation on Auguroom, revealed the rebilateral contractures Interview with the Dir August 26, 2013, at 2 Station revealed the recontractures in the loginterview confirmed the assess the resident's 483.20(d), 483.20(k)(COMPREHENSIVE COMPREHENSIVE COMPREHE	ad May 24, 2013, revealed a extensive assistance with all ling (ADL's), and had a range of motion on one emity.  Inst 28, 2013, in the resident's esident lying in the bed with of the lower extremities.  Bector of Nursing (DON) on estable that bilateral were extremities. Continued the facility failed to accurately contractures.  I) DEVELOP CARE PLANS  In results of the assessment of revise the resident's of care.  Is of care.  Is of care are sident's mental and psychosocial ed in the comprehensive escribe the services that are in or maintain the resident's ysical, mental, and g as required under ices that would otherwise	F 27	79	F 279 483.20 (d), 483.20 (k) Develop Comprehensive Plan Care  SS=D  Requirement:  A facility must use the results of assessment to develop, review a revise the resident's comprehensiplan of care.  A facility must develop comprehensive care plan for each	(1) of he nd ve	
],	be required under §48 due to the resident's e	3.25 but are not provided			resident that includes measurab objectives and timetables to meet	le i	

PRINTED: 09/04/2013 FORM APPROVED OMB NO 0038\_0301

STATEM	ENT OF DEFICIENCIES	KAN DEGREE OF VICES			OMB NO. 0				
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION 3	(X3) I	DATE SURVEY COMPLETED		
414145		445457	B. WING	;		1.	NO MOMAN		
	F PROVIDER OR SUPPLIER		7	5	STREET ADDRESS, CITY, STATE, ZIP CODE		) <del>8/28/</del> 2013		
EAST	TENNESSEE HEALTH O	ARE	ł		465 ISBILL RD				
- CAN IS	CI (DE LA DAZIONA)				WADISONVILLE, TN 37354				
(X4) ID PREFIX TAG	(   (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFID TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) RE	COMPLETION DATE		
F 279	under §483.10(b)(4) This REQUIREMEN	ge 5 . T is not met as evidenced accord review and interview	F 2	79	resident's medical, nursing mental and psychosocial needs are identified in the comprehen assessment.  1. Resident # 23 Care Plan	that sive			
	the facility failed to d	evelop a care plan to e for one resident (#23) of			updated on 8/28/2013 reflect current incontin status by MDS Coordinate	to ent or.			
	The findings included		ļ		100 % audit of all curresident care plans will completed by 9/20/13	be			
	January 18, 2012, wi Cerebral Vascular Ac Hypertension, and Do	mitted to the facility on th diagnoses including cident, Diabetes, epression.			THM MDS Consultant.	- :	·		
	(MDS) dated May 9, 3 occasionally incontine continent of bowel. Continent of a MDS date resident usually incontinent of	i			completion of assessment and care plan on 9/16/2013. If any nurse missed the inservice, he or she will be inserviced prior to return to work. Any new hires will be in-serviced	te ts : :- 1-			
F 280	plan last updated July Director of Nursing on a.m., in the facility cor the care plan failed to incontinence. 483.20(d)(3), 483.10(l	t)(2) RIGHT TO	:		orientation.  4. Nuise Management or THM MDS Consultant will complete audit of all completed/revised care plant daily M-F in Morning QA				
SS=D	PARTICIPATE PLANN The resident has the r Incompetent or otherw incapacitated under th participate in planning	ING CARE-REVISE CP  Ight, unless adjudged ise found to be e laws of the State, to			for 30 days and then weekly for 3 months, then biweekly for I month until substantial compliance is achieved. If compliance is not met the	, ,	Completed By: 09/20/2013		

DEPAR CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES		PR	INTED: 09/04/2013 FORM APPROVED
ISIMICMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	ON ON	NO. 0938-0301 X3) DATE SURVEY COMPLETED
		445457	B. WING		
NAME OF	PROVIDER OR SUPPLIER		.,	STREET ADDRESS, CITY, STATE, ZIP CODE	08/28/2013
	ENNESSEE HEALTH C			465 ISBILL RD MADISONVILLE, TN 37354	İ
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI) YAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	COMPLETION DATE
i	changes in care and A comprehensive ca within 7 days after th comprehensive asse interdisciplinary team physician, a register for the resident, and disciplines as determ and, to the extent pra the resident, the residegal representative;	treatment.	F280	Administrator/Nurse Management will re-inservice and continue monitoring until substantial compliance is achieved.  F280 483.20 (d) (3), 483.10 (k) (2) Right to Participate, Planning Care— Revise CP SS=D  Requirement: The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in	Completed By: 09/20/2013
1	by: Based on medical re- and interview, the fac- plan to address the us- washcloths for one re- residents reviewed.  The findings included: Resident #29 was adn bruary 22, 2012, with diagnoses	nitted to the facility on th readmission on June 21, including Diabetes Mellitus, izophrenia, Chronic Atrial Pneumonia, Morbid		planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident, the resident's family or the residents'	

(Right)..."

Medical record review of the Nurse's Admission/Readmission Assessment dated June

21, 2013, revealed "...Contractures: Hand

qualified

assessment.

legal representative, and periodically

reviewed and revised by a team of

after

persons

each

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINT	ED: 09/04/201
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES				FO	RM APPROVE
STATEME AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	O(1) PROVIDERIBLISPLIERICLIA IDENTIFICATION NUMBER:	(X2) Mi A. BUIL	יייט נוסנו	TIPLE CONSTRUCTION	(X3)	NO. 0938-039 DATE SURVEY COMPLETED
	··	445457	B. WIN	G			
NAME OF	PROVIDER OR SUPPLIER		1	7	STDEET ADDRESS OF A		08/28/2013
EAST T	ENNESSEE HEALTH C	ADE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 466 ISBILL RD		
		AVE.		Į	MADISONVILLE, TN 37354		
(X4) ID	SUMMARY STAT	TEMENT OF DEFICIENCIES	T ID	ــــا	<del></del>		
PREFIX TAG	(CAUR DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREF TAG	K	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRICE OF THE APP	II D be	COMPLETION OATE
F 280	Continued From pag	je 7	Fa	280	1. Resident # 29's care	nlen	
	Medical record revie	w of the June and July 2013,	1		updated 8/27/2013 to i	· histi	1
	i Nevapuulalion Orger	S (9VeAled "Keep padding	i		hond animals 1 1	iciude	i
	with placing 1 washe	loth to both naims to keen			hand splints/washclot	us by	ď
	nails from digging in	palms. Monitor daily."			MDS Coordinator.		! .
	Madlant same	***			2. 100% audit of all care	plans	1 :
	dated June 21 2012	v of the Admission Care Plan			was completed by 9/20	/2013	
	dated June 21, 2013, Contractures-hands-	revealed "Problem:			by THM MDS Consults	int	1
		on to paims"			3. Administrator/DON	_	
1	Medical record review	v of the current care plan			ADON in-serviced MD	and Land	
	uateo July 10, 2013, i	evealed the facility follows.			licensed nurses rega	odina Odlara	i 1
1	accidess the hand con	tracture and the unchalathe			accurate completion/rev	cong	1 1
}	and/or splints applica-	tion.		i	of care plans on 8/30/	1810 <u>N</u>	] [
	Douglass - Fall				and 9/16/2012 TE	2013	1
	Review of the undated	Nurse Aide		ļ	and 9/16/2013. If any	nurse	
j	Communication Work "Contractures hands	sheet revealed		Ì	missed the in-service,	ie or	1
[	revealed the hand spil	Internet review			she will be in-serviced	prior	1 !
].	application were not a	ddressed			to return to work. Any hires will be in-ser-	new	
1				-	during orientation.	nced	1 1
	Review of the nurse at	de care sheet, updated on		۱.	4. Nurse Management or 7		1
	'' '' '' '' '' '' '' '' '' '' '' '' ''	i ina shinte and/or		- 1	MDS Consultant		! I
	washcloths application	were not addressed.		-{	complete audit of	will	1 1
	Medical record review	of the telesters			completed/revised care p	all .	}
	taled August 21, 2013	, revealed "Keep padding			daily M-F in Morning	ans	
V	with washcloth or inflat	able short hand orthoses		1	for 30 days and then we	QA	
, t	o botu usuas to keed i	calls from dinging into		1	for 3 months, then biwer	kly	ĺ
ļ p	alms. Monitor daily."			$\prod$	for 1 months, then blwes	кiy	}
]_	St. 41	1		П	for 1 month until substan	tial	Į
	Diservation on August	26, 2013, during the lunch		]'	compliance is achieved.	If	[
ļ 41	itearitti tue alving room	i. FeVealed the resident in			compliance is not met	he	Completed By:
; H	geri-chair, prior to and	i during the resident being i			Administrator/Nurse	ŀ	
i k	ed, with no hand splint	s or washcloths in the		1	Management will re-		09/20/2013
ď	f the resident in the m	ation through out the day, sident's room, while in bed			service and contin	ue	
ļo	r in the geri-chair, neve	ealed the resident did not			monitoring until substant	al	1
h	ave hand splints and/o	r washcloths applied.	i		compliance is achieved.	1	

PRINTED: 09/04/2013 FORM APPROVED

ISTATE	MENT OF DEFINITION	& MEDICAID SERVICES			FORM	APPROVE
ANO PI	LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	(X3) DAT	. 0038_0304 E SURVEY PLETED
N/A B 4E	OF BOOK TOWN	445457	B. WING		1	
l l	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES	JD PREFIX	STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 PROVIDERS PLAN OF CODE STATE		28/2013
F 21		G IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE PRIATE	(XS) COMPLETION DATE
F 281 \$\$=D	Observation on August the resident, in the regeri-chair, revealed r washcloths in the hair finterview on August 2 the Minimum Data School MDS office, confirmed dated July 10, 2013, a contracture or the appand/or washcloths.  Interview on August 2 the Administrator and the dining room, confished updated July 29 Communication Works washcloth/splint applied 483.20(k)(3)(l) SERVIC PROFESSIONAL STATE The services provided must meet professional This REQUIREMENT by:  Based on medical recond interview, the facilities plints and/or washcloth physician for one reside residents reviewed.  The findings included:  Resident #29 was admit	ust 27, 2013, at 9:00 a.m., of esident's room, in a so hand splints and/or nots.  27, 2013, at 3:20 p.m., with et Coordinator (MDS), in the did not address the olication of the hand splints  7, 2013, at 4:00 p.m., with the MDS Coordinator, in red the nurse aide care, 2013, and the Nurse Aide sheet failed to address the ation.  CES PROVIDED MEET NDARDS  or arranged by the facility at standards of quality.  is not met as evidenced ord review, observation, y failed to apply hand has as ordered by the ent (#29) of thirty-one	F 281	F281 483.20 (k)(3)(l) Servi Provided Meet Profession Standards  SS=D  Requirement:  The services provided or arranged letter facility must meet profession standards of quality.  1. Resident #29 hand splints were applied on 8/27/13 by	Dal	
	Resident #29 was admit February 22, 2012, with	ited to the facility on readmission on June 21,	ļ	were applied on 8/27/13 by Restorative Aide.		

PRINTED: 09/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	OAT DECEMBER	· · · · · · · · · · · · · · · · · · ·		OWR M	OMB NO. 0938-039		
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(x3) C(	ATE SURVEY AMPLETED		
NAME OF		445457	B. WING		01	3/28/2013		
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE			
EAST T	ENNESSEE HEALTH C	ARE		466 ISBILL RD MADISONVILLE, TN 37354				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	2013, with diagnose Bi-Polar Disorder, S Fibrillation, Aspiration Obesity, and Coronal Medical record review Admission/Readmis 21, 2013, revealed "(Right)"  Medical record review Recapitulation Order with placing 1 washed an alls from digging in Medial record review August 21, 2103, review	s including Diabetes Mellitus, chizophrenia, Chronic Atrial on Pneumonia, Morbid ary Artery Disease.  In of the Nurse's sion Assessment dated JuneConfractures: Hand  In of the June and July 2013, is revealed "Keep padding sloth to both palms to keep palms. Monitor daily."  In of the telephone order dated realed "Keep padding with le short hand orthoses to leals from digging into palms.  In of the July and August in orthose to the lead of the	F 28	2. All residents with limitations were athe Therapy Staff for splints and proper placeme 8/27/2013 – 9/10/20 3. Administrator in-selicensed nurses, R. Aides, CNAs, R. Nurse and or personnel on 9/19/9/20/2013 that: Staff will apply, as monitor splints as until turned or restorative for main At this time, the Re Aides will monit document daily restorative service discontinued. Renurse will chart and weekly to a compliance, discontinued Restorative services, Nurse/and or Tr	functional audited by for need to ensure ent on 013. Erviced all estorative estorative therapy 2013 and Therapy sess, and ordered ver to atenance. Estorative for and until es are storative monitor maintain Once from Charge eatment monitor laily. If esed the			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES 1020<u>-8220, ON BMO</u> (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER 08/28/2013 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 485 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X8) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 281 Continued From page 10 F 281 in-serviced prior to return to work. Any new hires will be Observation on August 27, 2013, at 9:00 a.m., of in-serviced the resident, in the resident's room, in a during geri-chair, revealed no hand splints and/or orientation. washcloths in the hands. 4. Nurse management to audit daily for 30 days M-F in interview with Licensed Practical Nurse (LPN) #4 Morning OA and then on August 26, 2013, at 4:24 p.m., in the resident's weekly for 3 months, then room, with the resident present, confirmed the biweekly for 1 month until resident did not have hand splints or washcloths substantial compliance is applied. achieved. If compliance is Interview with Certifled Nurse Alde (CNA) #2 on not met the Completed By: August 24, 2013, at 4:24 p.m., on the 200 hall. Administrator/Nurse confirmed the resident did not have hand splints Management will re-in-09/20/2013 or washcloths applied since the CNA came on service and continue ! duty at 3:00 p.m. monitoring until substantial compliance is achieved. Interview with LPN #5 on August 27, 2013, at 9:00 a.m., in the resident's room, with the resident present, confirmed the resident did not have hand splints or washcloths applied. Further interview revealed the Treatment Administration Record (TAR) contained the documentation for the monitoring of the application of the hand splints and/or washcloths. Interview on August 27, 2013, at 1:45 p.m., with CNA #3, on the 200 hall, confirmed the CNA was on duty on August 26, 2013, and was assigned to the resident. Further interview confirmed the hand splints and/or washcloths were not applied

p.m. shift.

on August 26, 2013, during the 7:00 a.m. to 3:00

Interview on August 27, 2013, at 4:00 p.m., with the Administrator and the Minimum Data Set (MDS) Coordinator, in the dining room, confirmed the facility falled to apply/monitor the hand splints

DEPAI	RTMENT OF HEALTH	AND HUMAN SERVICES			F	RINTE	D: 09/04/201	13
CENT	<u>ERS FOR MEDICARE</u>	& MEDICAID SERVICES				FORM	M APPROVE	D
SIMILA	NT OF DEFICIENCIES FOR CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		<del>4</del> 45457	B. WING	3		1		
NAME OF	PROVIDER OR SUPPLIER			_	TOPET ADDRESS AND	80	/28/2013	╝
EART	EMMERCE MEANER				TREET ADDRESS, CITY, STATE, ZIP CODE 65 ISBILL RD			J
EMOIL	ENNESSEE HEALTH C	ARE			IADISONVILLE, TN 37354			- [
(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES	<del></del>				<del>"</del>	╛
PRÉFIX TAG	I FACH DEFICIENCY	MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 281	Continued From pag	no 11						1
		dding as ordered by the	F2	:81			]	l
	physician.	dding as ordered by the	<u> </u>	ļ			ļ	ı
F 314	483.25(c) TREATME	NT/SVCS TO	F3	4.4	Transaction and the contraction			1
SS=G	PREVENT/HEAL PR	RESSURE SORFS	гэ	14	F314 483.25 (c) Treatment/Serv	ices	l	ı
	!			ı	to Prevent/Heal Pressure Sores			l
	Based on the compr	ehensive assessment of a		ľ		ŀ		ı
	resident, the facility i	nust ensure that a resident			SS=G	ļ		
	who enters the facilit	y without pressure sores		ĺ	1	ŀ		
	individual's clinical or	essure sores unless the andition demonstrates that		- }	Requirement:	i		l
	they were unavoidab	le; and a resident having		Ì	1	-		ł
	pressure sores recei	ves necessary treatment and		- [	Based on the comprehens	ive		Į
	services to promote I	198iing, prevent infection and i			assessment of resident, the facil	like.		
	prevent new sores fro	om developing.		-	must ensure that a resident w	aty		1
		[		l'	enters the facility without press	no		ı
	This DEALIDENENT	is not met as evidenced			sorge ambas the lacinty without pressi	ne		l
	ph:	is not met as evidenced			sores unless the individual's clini	cal	1	
j	Based on facility poli	cy review, medical record		-	condition demonstrates that th	ey	i	
į	review, review of a m	edical dictionary			were unavoidable; and a reside	ent [		l
- 1	observation, and inter	view the facility failed to			having pressure sores receiv		- 1	i
- 1	provide prompt treatn	nent for a pressure ulcer for			necessary treatment and services	to	}	i
ľ	one resident (#75) of	thirty-one residents			promote healing, prevent infection	<b>n</b>	ŀ	
	reviewed. The racility.	s failure resulted in harm for			and prevent new sores fro		ł	
ŀ	. Soldotti if i O.				developing.		F	
	The findings included	:			<b></b>	-	į	
1					1. Resident #55 was placed of	_	j	
	Review of facility police	y Skin Care Guidelines	•	11	sand had 0/17/10	<u> </u>	1	
	Object December 2012	2, revealed "orders for			sand bed 8/17/12, and san		j	
],	montra cate Mit 06 00.	tained and initiated at the fiedPressure ulcers must		11	bed will continue as long a	ıs	Į	
Į.	be assessed and mea	induminiessure uicers must			clinically necessary	ļ		
į,	weekA pressure ulc	er is a localized injury to the		$\prod$	2. An audit was performed of	n		
	skin and/or underlying	tissueusuality over a boney		11	9/19/2013 on all residents to	ا ه	]	
: 1	prominence, as a resu	ilt of pressure, or pressure		-	ensure all residents properly			
<b>;</b>	in combination with sh	ear and/or friction"			treated for any existing elsi-		ŀ	

conditions

by

Wound

PRINTED: 09/04/2013 FORM APPROVED

STATEME! AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP		FORM APPROVE QMB NO. 0938-030 (X3) DATE SURVEY		
			A. BUILDING	·	CO	NTE SURVEY IMPLETED	
NAME OF	PROVIDER OR SUPPLIER	445457	B. WING	<u> </u>	]		
			S	TREET ADDRESS, CITY, STATE, ZIP CODE	08	/28/2013	
CHO!!	ENNESSEE HEALTH	CARE	] 4	65 ISBILL RD			
(X4) IO	SUMMARY ST	ATEMENT OF DEFICIENCIES		ADISONVILLE, TN 37354			
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 314	Continued From pa	200 12		on outer)		<u> </u>	
ļ	Resident # 75 upp	age 12	F 314			ŀ	
- 1	January 7 2012 o	admitted to the facility on nd readmitted on December		Treatment Registered Nur			
i	11, 2012, with diag	noses including Hypertension,	<u> </u>			j	
]:	Cirrhosis, Aphasia	Head Trauma, Right		Tuesday		l	
į	Hemiparesis, Neuro	ogenic Bladder, and Decubitus	1.		h		
1	Ulcer.	sacrio biacca, and becubitus	] ]	resident will be assesse	d	- 1	
	Madical account	_	] [		2	- 1	
- 1,	INCORPITED TO THE	ew of a hospital Discharge	[ ]	nurses, daily by CNA	.	- 1	
	comment caled Ma	V 26, 2012 revealed * Au_a	11	weekly skin assessments by	,	į	
		IDRDITAL COMPONING ASSOCIATION	- 1	11-7 nurses for any change		į	
	Officials mirabilic and	eal area had grown out		in skin condition.	*	1	
18	Staphylococcus Aur	i MRSA (Methicillin Resistant; eus)patient underwent	11		- 1	ľ	
1,1	nascre had surgery:	Of the decubitue	11	commission mae iv		- 1	
"	wooiaggressive w	MING core wee	11	serviced by the Regional	- 1		
[0	ronenospital cours	A for unused some	[	Director of Operations on			
1 67	emory remie women	t slowly booled by	11	9/20/2013 that any specialty	1.1	1	
n	leed ongoing wound	care at the nursing home"	] ]	item ordered by a physician will be processed		- 1	
			1 1			1	
ä	lated May 2012	v of the Treatment Record	l i	immediately with	11	ļ	
(s	tage) II ulcer R butt	ealed "May 28, 2012,ST	11	verification of expected	11	- 1	
1,		OCK	11	delivery with Physician to	11	!	
M	ledical record review	of a Weekly Wound	-11	provide alternate if item		}	
1 1	HATEN SIGN 22912V	May 28 2012		unavailable in a timely	] ]	1	
	·Lucatori. It billines			manner. All Physicians	!		
- 1 -	20-12Sidde ii ann	Park ac Stage II court	11	notified via letter on	} }	ŀ	
1 1 2 2 2	""MALLY "P. D. CALL RESENTA		11	9/20/2013 that physician will	1.	i	
1 400	ohnia a's cili''' beum	OUDG: intact graphed access	11	need to provide an alternate	[-	- 1	
VIS	sibleno odorrese	mbles shear/friction"		if item unavailable in a	- <b>-</b>		
Me	edical record review	of a Braden Scale for	- 11	timely manner by the	- }		
150	eoicting Pressure Sc	Ore Risk dated June 7	11	Administrator. The licensed	- 1	]	
20	12, revealed Total S	core 14 moderate risk"	- 11	nursing staff and CNAs were in-serviced			
- 1		of a Social Services Notes		Administrator, DON, and		ł	
dat	led June 11, 2012 M	or a Social Services Notes evealed "application	- 11	ADON on 9/16/13 on		•	
1 ted	uest for a sand bed	to (insurance)	11	preventative skin care,	İ	ł	
tod	ayawaiting respon	se" (a "sand bed" is a	ļj	nutrition and hydration.	ŧ	1	

PRINTED: 09/04/2013 FORM APPROVED

STATEME AND PLAN	NT OF DEFICIENCIES VOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLA	ROVIDER/SUPPLIEDIO			
	2011016	IDENTIFICATION NUMBER:	A BUILDING		(CC3) DA	D. 0938 03 TE SURVEY MPLETED
NAME OF	PROVIDER OR SUPPLIER	445457	B. WING	<u> </u>	1	
	ENNESSEE HEALTH C		46	REET ADDRESS, CITY, STATE, ZIP CODE 6 ISBILL RD ADISONVILLE, TN 37354	<u>  08</u>	/28/2013
PRÉFIX TAG		EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
MA (% C C C C C C C C C C C C C C C C C C	fluidized air bed. Rev Dictionary, 8th Edition air bed: "minimizes pi weight evenly over the flow of temperature of upward through nume ceramic microspheres  Medical record review Progress Note dated of since last documented "Location: R buttock 5-28-12Stage II appoint (length) 12 cm (centim (depth) UTD (unable to denudedOdor: yes) flescriptions: Wound be dedical record review of status post) hospitalize occyx stage IV pressu occyx stage IV pressu occyx stage IV pressu occyx wound with open and bed)specialty m ossible)"  edical record review of optication (for the sand ourrent Procedure Tem ourrent Procedure Tem ordical record review of ordical record review of ourress Note dated Jun Location: R buttock/sa astageable)Tissue Da	riew of Mosby's Medical In, 2009, revealed a fluidized ressure and distributes e support surface. A gentle contrilled air is projected brous yiny openings called s.")  of a Weekly Wound flune 12, 2012, (two weeks i assessment) revealed /sacrumDate of Onset: ears as Stage IISize: L ears as Stage IISize: L eater) W (width) 5.5 cm D o determine)Periwound: Exudate: moderateOther ed is 100 % slough"  of a Physician's Progress pl2, revealed "S/P ation for surgical repair of re woundheels intact in areaslooks like wound not on specialty mattress lattress ASAP (as soon as reaters ASAP (as soon as f a Social Services Notes wealed "the precent bed) was missing a CPT minology) codefaxed  a Weekly Wound le 19, 2012, revealed	F 314	DON/ADON in-servi wound nurses regard support surfaces to prom healing was completed 9/18/13 and 9/19/13. If a nursing staff missed the service, he or she will be serviced prior to return work. Any new hires will in-serviced durit orientation.  4. Administrator, ADON, an Wound Treatment Tear conference call with QSource Representative Julie Clark and Beth Herches to discuss Pressure Ulcer Improvement on 9/19/2013. As participant in the CMS QAPI Program, the facility will implement a Pressure Ulcer Performance Improvement as focus for our QAPI initiative. Nurse Management will review new wound care orders, and will review with wound care nurse and doctor as needed for change of support surfaces/treatment as needed daily in morning QA for 30	ced ing ote by ny in- in- to be ag  d	npleted By: 20/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 09/04/2013 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING\_ COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER 08/28/2013 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X6) COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 314 Continued From page 14 F 314 Medical record review of a Social Services Note days M-F, and then weekly dated June 20, 2012, revealed "...(insurance) for 3 months, then biweekly: requested clinical info (information) on this patient for 1 month until substantial (in relation to the June 11, 2013 order for the sand bed)...info r/t (related to) pressure ulcers compliance is achieved. If faxed..." compliance is not met, Administrator/Nurse Medical record review of a Weekly Wound Progress Note dated June 25, 2012, revealed management will re-in-...Location: R buttock/sacrum...Tissue Type: service and continue Necrotic/Eschar (dead tissue) Odor: yes...6-25-12 monitoring until substantial wound c/s (culture and sensitivity) collected... Completed By: compliance is achieved. Medical record review of a Social Services Note 09/20/2013 dated June 25, 2012, revealed "...called (insurance) today to f/u (follow up) on status regarding sand bed..." Medical record review of a Social Services Note dated June 29, 2012, revealed "...spoke with (insurance) today to f/u on progress with sand bed...SSD (Social Service Director) clarified that this patients doctor was wanting him/her to have a sand bed...\* Medical record review of a Physician's Progress Note dated June 30, 2012, revealed "...wound still draining...wound c/s grew out MRSA..." Medical record review of a Weekly Wound

Medical record review of a Social Services Note FORM CMS-2567(02-99) Previous Versions Obsolete

Progress Note dated July 2, 2012, revealed "...Location: R buttock/sacrum...Date of Onset:

unst...Periwound: excorlation shearing from tape...Exudate: copious...Other descriptions: MRSA infection. Surgeon to be called today to have apt (appointment) made...Pain; 0..."

5-28-12...Stage unst appears as

Event ID: 813311

Facility ID: TN6201

if continuation sheet Page 15 of 31

CENT	ERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORI	D: 09/04/20 MAPPRQV	ΈD
ISIALEME	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
<u> </u>		445457	B. WING					- 1
NAME O	F PROVIDER OR SUPPLIER		'	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	80	/28/2013	ᅴ
EAST 1	TENNESSEE HEALTH C			465 (	SBILL RD NSONVILLE, TN 37354			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  C IDENTIFYING INFORMATION)	ID PREFID TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	COMPLETIO DATE	и
F 314	Continued From pag	ne 15	F 3	14			-	7
		evealed "resident was sent	га	14				
	dated July 3, 2012, n	w of a Social Services Note evealed "called (insurance) o receive sand bed)"						
	dated July 9, 2012, n	w of a Social Services Note evealed "(insurance) rep ad bed was approved"						
	"Location: R buttoc 5-28-12Stage unst	July 11, 2012, revealed				,		
	"Location: R buttoc	v of a Weekly Wound July 16, 2012, revealed v/sacrumDakin's (solution nfections) used to treat						
The state of the s	"Location: R buttock	July 23, 2012, revealed //sacrumDecline from last more friable (breakable) T (due to) increase		- Addition				
İ	dated July 24, 2012, re	of a Social Services Note evealed "followed up with cont (continue) to push roduct (sand bed)"						
ļ :	Medical record review Note dated July 27, 20 May Concernlack of	of a Physician's Progress 13, revealed "To Whom It bed mobility without						

ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	FORM APPRI OMB NO. 0938- (X3) DATE SURVE	
		445457	B. WING_		1 "	MPLETED
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COL	08	/28/2013
AST T	ENNESSEE HEALTH C	ARE	- 1	485 ISBILL RD	Æ	
X4) ID	SUMMARY STAT	TEMENT OF DEFICIENCIES		MADISONVILLE, TN 37354		
REFIX TAG	! ICAUTI DEPKARNITY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	MAR D DE	(X6) COMPLETA DATE
314	Continued From pag	10 16				<del> </del>
	assistancebed hou	ind; had developed decubitus	F 314	1		
	CIOCIO MINCHI LENNINCIDA	n Shingani ta basi daga d	l			[
J	LACO OHIA MINI SULL D	PC 25 midannod by fait at		1		
	sand bed to support.	Warv 2 2012) when and at 1		1		
		<b>!</b>		1	į	
- 1	Medical record review	w of a Weekly Wound		Í		
	····Location: K bittod	July 30, 2012, revealed			İ	
- 1	iardecobibus. Odo:	C UGO Othor downers			[	
, ,	, we forming (C) 2(3)Lief	1 2020 for for the annual at 1			ĺ	
- }	wound. Tip of coccyx	bone noted"	i			
	Medical record review	of a Physician's Progress	}		1	
, , ,	TOTAL ACTION OF ME	JIV fevered " i	f			
	anaidhe s	Sind had incurrence			1	
11	ompany approval…de Ofection. Plant aveille	ecubitus uicer with wounding sand bed, surgical eval	ſ		1	
	OTOLOGICUM IN LIMITATION D	PPRIOR AT BANK WILL	-		-	
b	ed to help will continu	le to deteriorate"			1	
N	fedical record review	of a Physiciants T. L.	- 1		1	
	ו בי אותר מסוסה איף יי	1317 FOMODION 9 FM 1			1	
1	ave Social Worker ch	eck on status of sand bed	- 1		ļ	
"	ind let tile KNOW"		J		ſ	
M	edical record review (	of a Weekly Wound				
( 1574	CUITUSS INDIA NAIAN A:	DONIE & DOAD			1	
	revealibit is diffickly	sacrumExudate: tion; deeper wound bed			]	
fro	om coccyx to upper ha	alf of wound bed"			}	
ı		f a Social Services Notes				
ua	140 August 7, 2012. R	BVBSIEd " contacted	1		j	
1 (10)	surance) againhave	en't received approved	}			
sa	nd bed"	, , ,				- 1
Me	dical record review of	f a Weekly Wound				- 1
Pro	ogress Note dated Au	and D does	}		Į.	

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES			1 PE	NTEN	09/04/2013
CEIAI	ERS FUR MEDICARE	& MEDICAID SERVICES				FORM	APPROVEC
CONTRACTOR	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING			. 0938-0391 E SURVEY PLETED
		445457	i			90,1	
NAME O	F PROVIDER OR SUPPLIER	7-5407	B. WINK			08/2	28/2013
EAST	ENNESSEE HEALTH C	Abr		STREET ADDRESS, CITY, STATE, ZIP 465 ISBILL RD	CODE		
<u> </u>	THE THE PERIOD CO.	ARE		MADISONVILLE, TN 37354			
(X4) ID PREFIX TAG	I LEACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREF TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO	N SHOULD BI E APPROPRIA	E VIE	(X5) COMPLETION DATE
F 314	Continued From pag	- 47			<del></del>		<del></del> -j
	"Location: R buttor	ck/sacrumSize: L 10 cm W	F3	14			
	10.5 cm D 2 cmEx chg (change) 6/30/1:	Udate: copious I ast ty order i			***		
	Medical record review	w of a Weekly Wound				- 1	
	Progress Note dated	AUGUST 8 2012 revealed		ļ		ĺ	
	appears as Stage II	MPressure Hicer Store II				ĺ	
	8/8/12Periwound: F	120 (water\hister		1			Ī
	intactExudate: fluid	filled"					
	Medical record review	v of a Weekly Wound				j.	į
į	rivuless note dated	Aboutef & 2042 Paraglast					
1	Chack Old IZPIBSS	Malleolus (ankle). Date of ure Ulcer: Stage IV appears		}			}
ļ	45 & State (V., Size: )	15W20mB020L		}			ļ
1	4000 IULIONE/COMMON	ts: silver surgical appliance The top of screw is noted"				];	
	Medical record review	of a Braden Scale for					
J	rredicting Pressure S	ore Risk dated August 8, core 13 moderate risk"					
	Medical record review dated August 9, 2012,	of a Social Services Notes					
	Auministrator's advice	this writer collect a li		*			
	representative of (sand they could help us get	bed company) to eas if		}			l
Ň	writer explained urgent	nature of the situation"					
1	Medical record review	of a Weekly Wound					
ļr	Togress Note dated A	ugust 13, 2012, revealed sacrumSize: L 10 cm W					
1	0.5 cm D 1 cmExud	ate: copious,"					
Ň	fedical record review of	of a Weekly Wound					
	TOGTESS Note dated A:	Igust 13, 2012, revealed Pressure Ulcer: Stage II				ĺ	ļ
а	ppears as Stage IDa	ite of Onset:					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA <u>OMB NO. 0938-0391</u> (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A BUILDING\_ 445457 B. WING NAME OF PROVIDER OR SUPPLIER 08/28/2013 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 466 ISBILL RD MADISONVILLE, TN 37354 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (203) COMPLETION DATE TAG PREFIX TAG DEFICIENCY) F 314 | Continued From page 18 F 314 8/8/12...Periwound: H20 (water) blister intact...Exudate: fluid filled..." Medical record review of a Weekly Wound Progress Note dated August 13, 2012, revealed "...Location: R Lateral Malleolus...Date of Onset: 8/8/12...Pressure Ulcer: Stage IV appears as a Stage IV...Size: L 2 W 1.5 cm D 0.2..." Medical record review of a Social Services Notes dated August 14, 2012, revealed "...left VM (voice mail)...to check on progress (of sand bed)... Medical record review of a Social Services Notes dated August 17, 2012, revealed "...sand bed finally arrived today...patient smiled when first laid on it seemed to breathe easier..." Medical record review of a Physician's Telephone Order dated August 17, 2013, revealed "...D/C (discontinue) order for surgeon r/t (related to) decubitus ulcer try trial with sand bed ... " Medical record review of a Physician's Progress Note dated August 19, 2012, revealed "...doing better sand bed received has been on it several days wound in gluteal area healing...healing decubitus ulcer..."

FORM CMS-2587(02-99) Previous Versions Obsolete

Medical record review of a Weekly Wound Progress Note dated August 20, 2012, revealed "...Location: R buttock/sacrum...Size: L 10 cm W 10 cm D 1 cm...Exudate: copious...Other

is deeper...Other: (sand bed) 8-17-12..."

Medical record review of a Weekly Wound Progress Note dated August 20, 2012, revealed "...Location: R Ischium ...Resolved...(sand bed

description/comments: area around coccyx bone

Event (D:813311

Facility ID: TN6201

If continuation sheet Page 19 of 31

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION MB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER 08/28/2013 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X6) COMPLETION TAG EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 314 Continued From page 19 F 314 manufacturer's name) bed August 17, 2012..." Medical record review of a Weekly Wound Progress Note dated August 21, 2012, revealed ...Location: R Lateral Malleolus...Date of Onset: 8/8/12...Pressure Ulcer: Stage IV appears as a Stage IV...Size: L 1.8 W 0.8 cm D 0.2...Other descriptions/comments: silver appliance is still visible..." Medical record review of a Weekly Wound Progress Note dated August 27, 2012, revealed "...Location: R buttock/sacrum...Size: L 9 cm W 9 cm D 0.8 cm...Odor: none...Undermining/Tunneling: none..." Medical record review of a Weekly Wound Progress Note dated August 27, 2012, revealed ...Location: R Lateral Malleolus...Date of Onset: 8/8/12...Pressure Ulcer: Stage IV appears as a Stage IV...Size: L 1.5 W 0.8 cm D 0.2... Medical record review of a Weekly Wound Progress Note dated September 3, 2012. revealed "...Location: R buttock/sacrum...Size: L 7 cm W 8.5 cm D 0.5cm...Odor: none...Undermining/Tunneling: none..." Medical record review of a Weekly Wound

Progress Note dated September 10, 2012, revealed "...Location: R buttock/sacrum...Size: L

Medical record review of a Weekly Wound Progress Note dated September 17, 2012, revealed "...Location: R buttock/sacrum...Size: L

6.5 cm W 8 cm D 0.3 cm...Odor: none...Undermining/Tunneling: none..."

6 cm W 7 cm D 0.2 cm...Odor: none...Undermining/Tunneling: none..."

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PF	RINTE	D: 09/04/201
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			V		FOR	M APPROVE
ISTATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		(X3) D/	0. 0938-039 TE SURVEY MPLETED
		445457	8. WING			l		Moman
NAME OF	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP COD	E	98	V28/2013
EAST TE	ennessee Health C	ARE			56 ISBILL RD IADISONVILLE, TN 37354			
(X4) tD	SHAMARY STA	TEMENT OF DEFICIENCIES	<del>1</del>	$\overline{}$				<u>,</u>
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFU TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDE		(X5) COMPLETION DATE
F 314	14 Continued From page 20		F3	14				
	Progress Note dated revealed "Location 5.8 cm W 6.8 cm D noneUndermining Medical record revie been discharged to the hogola, and readmitted discharged to the hogola, and readmitted Continued medical mesident had surgical ulcers.  Observation on Auguster resident's room, sand bed and the wowound care/dressing the right buttocks had cm x 0.8cm; 2) 0.06; and/or drainage note Interview with the Soon August 28, 2013, office, revealed the Sobtain insurance appute delivery of the sand but to August 17, 2012. F"The facility consider	Tunneting: none"  In revealed the resident had the hospital on September I on October 8, 2012, spital on November 27, and December 11, 2012, ecord review revealed the I correction of decubitus ast 27, 2013, at 1:30 p.m., in revealed the resident on a found care nurse provided a change. The decubitus on the two areas measuring 1) 1.5 to 0.5cm with no depth, odor.						
	Interview with the Ass (ADON) on August 20 Administrator's Office physician had been n	sistant Director of Nursing 3, 2013, at 9:41 a.m., in the 4, revealed the resident's 4 otified the facility was having 4 he sand bed. Continued						

DEP/	RTMENT OF HEALTH	AND HUMAN SERVICES			PRAITE	D: 09/04/2013
CEN	TERS FOR MEDICARE	& MEDICAID SERVICES			FORM	M APPROVED
19 WIEW	ENTO: UE DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	4400 4.0.0		OMB NO	3. 0938-0391
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:	A BHILD	TIPLE CONSTRUCTION		TE SURVEY
			1 × 60EL		1 60	MPLETED
<u> </u>		445457	B. WING	<del></del>		
NAME	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		/28/2013
EAST	TENNESSEE HEALTH C	ADE	]	466 ISBILL RD		
			J	MADISONVILLE, TN 37354		i
(X4) ID PREFO	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		DVC)
TAG	REGULATORY OR LE	SC IDENTIFYING INFORMATION	PREFD	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DRE	COMPLETION
			""	DEFICIENCY)	PRIATE	DATE
F 04			<del>                                     </del>			<del></del>
F 31	- aguarance i rout bar	ge 21	F3	14		i 1
	interview revealed th	ne physician stated he wanted		ļ		}
	the resident to have	the sand bed and continue to				
	try 9to obtain the be	a).		İ		! F
	Interview with the Ad	iministrator on August 28,			:	
	2013, at 9:43 a.m., ii	the Administrator's Office				<u> </u>
	i revealed the facility of	ild not purchase/rent the			{	
	sand bed because it	ne facility did not have a				1
	contract with any of t	he companies furnishing		•]	-	!
	facility had attempted	ed interview revealed the to get insurance approval			ĺ	•
	for the sand bed from	a supplier from June 11,			ł	- 1
	2012, through Augus	t 17, 2012 (67 days)		1	}	
	i Further interview con	firmed the resident's		1		- 1
	decubitus ulcer on the	e R buttock/sacrum		1		1
	continued to deteriora	ate and the resident		ļ	- 1	i
	developed two more	pressure uicers.				
	Interview with the res	ident's physician by				
	i telephone on August :	28, 2013, at 11:40 a m				i
	revealed the resident	had been hospitalized for . !			!	
	surgery related to the	wounds and the surgeon			}	1
	resident. Continued in	provide a sand bed for the				l
	resident had done we	If on a sand had in the				ĺ
	hospital. Further inter	view revealed the physician				1
ı	had been unsure of th	e time frame but stated "It		İ	1	
	took a while for the in:	surance company to		1	ĺ	
	approve the bed and t	he resident's wounds		•		1
E 945	continued to deteriora				1	!
CCD	483.25(d) NO CATHE RESTORE BLADDER	IEK, PREVENT UTI,	F 315	F315 483.25 (d) No Cathe	eter.	i
ວວ <b>=</b> ບ	NEOTONE DEADUER	•		Prevent UTI, Restore Bladder	,	1
	Based on the resident	's comprehensive		Diaudel	1	1
	assessment, the facilit	v must ensure that a		SS=D		1
Į	resident who enters th	e facility without an				1
}	indwelling catheter is r	not catheterized unless the			į	ļ
	resident's clinical cond	lition demonstrates that				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 09/04/201 FORM APPROVE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-039 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING\_ (X3) DATE SURVEY COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER 08/28/2013 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDERS PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 315 | Conlinued From page 22 F 315 Requirement: catheterization was necessary; and a resident who is incontinent of bladder receives appropriate Based treatment and services to prevent urinary tract on the resident's infections and to restore as much normal bladder comprehensive assessment, the function as possible. facility must ensure that a resident who enters the facility without an This REQUIREMENT is not met as evidenced indwelling catheter is not bv: catheterized unless the resident's Based on medical record review and interview clinical condition demonstrates that the facility failed to ensure that a resident who was only occasionally incontinent of bladder and catheterization was necessary; anu a always continent of bowel was revaluated after a resident who is incontinent of decline in continence for one resident (#23) of bladder receives thirty-one residents reviewed. appropriate treatment and services to prevent The findings included: urinary tract infections and to restore as much normal bladder function as Resident #23 was admitted to the facility on January 18, 2012, with diagnoses including possible. Cerebral Vascular Accident, Diabetes, Hypertension, and Depression. 1. Resident #23

FORM CMS-2567(02-99) Previous Versions Obsolete

bladder..."

Medical record review of a Minimum Data Set (MDS) dated May 9, 2013, revealed " ...resident

occasionally incontinent of urine..." Continued

medical record review of a MDS dated May 23,

Interview with the Restorative Nurse, at the

The facility must ensure that the resident

for a possible bladder program. F 323 483.25(h) FREE OF ACCIDENT

SS=D | HAZARDS/SUPERVISION/DEVICES

2013, revealed " ... resident usually incontinent of

nurse's station, on August 28, 2013, at 9:21 a.m.,

confirmed the resident had not been reevaluated

Event ID: 8(3311

Facility ID: TN6201

If continuation sheet Page 23 of 31

licensed

began

restorative toileting program

and updated current census

list to reflect all residents

who are incontinent of B/B.

The THM MDS Consultant

Nurse audit completed on

all

9/19/13 to reflect

3. Administrator/DON/ADON

incontinent residents.

in-serviced

On 9/10/13, ADON audited

9/3/13.

ΩD

PRINTED: 09/04/2013 FORM APPROVED

STATEME	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					
NAME OF		445457	B. WING_				
	PROVIDER OR SUPPLIER ENNESSEE HEALTH O	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE 485 ISBILL RD MADISONVILLE, TN 37354		<u>8/28/2013</u>	
(X4) ID PREFIX TAG	( LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	1 C DE	(X5) COMPLETION DATE	
F 328 4	catheterization was who is incontinent of treatment and service infections and to restruction as possible.  This REQUIREMENT by: Based on medical retreatment of by: Based on medical retreatment of by: Based on medical retreatment of by: Catheter in continence the facility failed to en was only occasionally always continent of by decline in continence thirty-one residents retrieved thirty-one residents retrieved the findings included Resident #23 was add January 18, 2012, with Cerebral Vascular Activation, and Democration and Democratical record review (MDS) dated May 9, 2 occasionally incontine medical record review 2013, revealed "restoladder"	necessary; and a resident bladder receives appropriate tes to prevent urinary tract tore as much normal bladder.  T is not met as evidenced ecord review and interview insure that a resident who y incontinent of bladder and owel was revaluated after a for one resident (#23) of eviewed.  : mitted to the facility on h diagnoses including cident, Diabetes, pression.  of a Minimum Data Set 1013, revealed "resident int of urine" Continued of a MDS dated May 23, ident usually incontinent of estorative Nurse, at the pust 28, 2013, at 9:21 a.m., had not been reevaluated program.  CCIDENT SION/DEVICES	F 31:	nurses 8/30/2013 9/16/2013 that any reswith decline in comstatus must have a program initiated. If nursing staff missed the service, he or she will be serviced prior to return work. Any new hires with in-serviced decrentation.  4. IDT will review any admissions, readmissions, readmissions, and new assessments capture incontinence appropriate treatment prevention of urinary infections and to reston much normal black function as possible morning QA M-F for days, and then weekly for months, then biweekly for month until substant compliance is achieved. Compliance is not a Administrator/Nurse Management will re-	iment B&B any e in- e in- n to ill be uring new ions, to for and tract e as idder in 30 or 3 or 1 ntial	Completed By: 09/20/2813	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event (D: 813311

Facility ID: TN6201

If continuation sheet Page 23 of 31



#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

LENI	EKS FOR MEDICARI	AND HUMAN SERVICES  & MEDICAID SERVICES		F	RINTED: 09/04/201; FORM APPROVED
במוביותיטו	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
<u> </u>		445457	B. WING	g	
NAME O	F PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	08/28/2013
EAST	ENNESSEE HEALTH C	ARE		465 ISBILL RD MADISONVILLE, TN 37354	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	DE CONTRACT
	employee was attented from w/c (wheelchal movedleg and bed lowered to floor with linterview with the Di August 27, 2013, at office, confirmed the falled to use the required been implement transferring the resid be lowered to the floor 483.60(a),(b) PHARM ACCURATE PROCE.  The facility must providings and biologicals them under an agree §483.75(h) of this particensed personnel law permits, but only supervision of a license Afacility must provide (including procedures acquiring, receiving, dadministering of all druthe needs of each resident.	npting to transfer resident r) to bed. Resident ame unbalanced and was out injury"  rector of Nursing (DON) on 3:00 p.m., in the DON's Certified Nursing Assistant aired sit to stand lift (which ed March 10, 2013) while ent, and the resident had to be during the transfer.  MACEUTICAL SVC - DURES, RPH vide routine and emergency to its residents, or obtain ment described in t. The facility may permit to administer drugs if State under the general sed nurse.  pharmaceutical services that assure the accurate lispensing, and ugs and biologicals) to meet ident.  oy or obtain the services of who provides consultation rovision of pharmacy	F 42	orientation program (can extended for up to the weeks) for all memployees. The orientation checklist will be completed and placed in employee find once CNA is deem competent in all are covered by orientation checklist.  4. Nurse management with monitors deither the terms of the monitors deither the terms of the can be a second to the can be a	day be two ted de, ed as on ill f f t  Completed By:
]-	This REQUIREMENT	is not met as evidenced			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (PC) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING 445457 B. WING NAME OF PROVIDER OR SUPPLIER 08/28/2013 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL FID MADISONVILLE, TN 37354 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X3) MPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 425 Continued From page 25 F 425 F425 483.60(a),(b) Pharmaceutical SVC-Accurate Procedures, RPH Based on medical record review, review of pharmacy medication delivery records, facility policy review, and interview, the facility failed to SS=D provide pharmaceutical services for one resident (#97) of thirty-one residents reviewed. Requirement: The findings included: The facility must provide Resident # 97 was admitted to the facility at 5:00 pharmaceutical services (including p.m., on Friday, April 12, 2013, with diagnoses procedures that assure the accurate including Diabetes Mellitus, Hypertension, End Stage Renai Disease, Hemodialysis, Bradycardia, acquiring, receiving, dispensing and and Coronary Artery Bypass Graft. Further review administering of all drugs and revealed the resident left the facility Against biologicals to meet the needs of each Medical Advice on April 16, 2013, at 0945 (9:45 resident. a.m.). Medical record review of the physician orders 1. Resident WAS dated April 12, 2013, included Phos Lo Gel Cap discharged home Against (phosphate binder) 1,334 mg bld (milligrams Medical twice daily), Catapres TTS-3 (hypertension) q Advice (every) 7 days, Dilacor XR (hypertension) 180 mg 4/16/2013. bid, and Loniten (hypertension) 2.5 mg HS 2. Audited all current residents (bedtime). to ensure all medications Medical record review of the physician telephone available at facility for orders dated April 13, 2013, revealed dispensing on 8/28/2013 by "...Clarification orders: Phos Lo Gel cap 1334 mg Charge Nurses. On 9/6/13 BID start when available; Catapres TTS-3 q 7 days start when available; Dilacor XR BID 180 mg main pharmacy. start when available..." Ampharm secured another back-up pharmacy which is Medical record review of the April 2013

circled;

revealed the following:

Medication Administration Record (MAR)

p.m.) and April 13 at 0900 (9:00 a.m.) were

1.) Phos Lo Gel Cap bid: April 12 at 2100 (9:00

of

open 24 hours 7 days a

week, which also maintains a

selection

greater

medications.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING\_ COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER 08/28/2013 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RO MADISONVILLE, TN 37354 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) DATE DATE PREFIX (EACH, CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 425 Continued From page 26 F 425 3. Nursing management in-2.) Catapres for 7 days: April 13 was circled and serviced licensed nursing there was no further documentation regarding the administration of the medication; staff on 9/6/13 and 9/16/13 3.) Dilacor bld: April 12 at 2100, April 13, 15, and on procedures/protocol for 16 at 0900, were circled; there was no when medication is not documentation for April 14 regarding the available. Licensed nurses medication administration; and no documentation in-serviced on new addition of any other 2100 medication administrations; of a pharmacy for back up on 4.) Loniten at HS: April 12, 13, 14, and 15 were 9/6/13, 9/16/13, and 9/19/13 by DON and ADON. If any circled. nursing staff missed the in-Medical record review of the back of the MAR service, he or she will be inrevealed no documentation. serviced prior to return to work. Any new hires will be Review of the back-up pharmacy delivery record in-serviced dated April 12 and 13, 2013, revealed the Phos during orientation. Lo Gel Cap (equivalent) was delivered to the 4. Nurse facility on April 13, 2013. Further review revealed Management will no delivery of Catapres, Loniten or Dilacor. check all new admission orders to ensure medications Review of the main pharmacy delivery record are available daily M-F for revealed medications were delivered to the facility on April 16, 2013, at 5:22 p.m., after the resident 30 days and then weekly for had left the facility. 3 months, then biweekly for l month until substantial Review of the facility policy entitled "Admissions", compliance is achieved. If dated July 2013, revealed "...2.) Nurses are Completed By: responsible for checking off Physician not met, Administrator and Orders...and seeing that orders are followed. Nurse Management will re-09/20/2013 This includes transcribing orders onto MAR and in-service/re-educate notifying Pharmacy....\* until substantial compliance is Review of the facility policy entitled achieved.

"Documentation Of Med (Medication) Pass" revealed "...Omissions due to refusal,

MAR with explanation on the back..."

hospitalization, leaves, etc. must be noted on the

PRINTED: 09/04/2013 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
ļ		445457	B. WING			08/28/2013	
	PROVIDER OR SUPPLIER INNESSEE HEALTH O	ARE		STREET ADDRESS, 465 ISBILL RD MADISONVILLE,	CITY, STATE, ZIP CODE TN 37354		
(X4) ID PREFIX TAG				(EACH CO	PER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD ERENCED TO THE APPROPE DEFICIENCY)	8E	(X5) COMPLETION DATE
	the Assistant Direct ADON's office, conf Administration Recomedication meant it administered. Furth facility failed to folio reason for the failure medication.  Interview on August phone with the back revealed the facility the pharmacy on Aprevealed the facility Gel Cap and the Cawritten and was crosprovided to the pharconfirmed the Lonite stock and not provide interview revealed the pharmacy request of Gel Cap, Catapres a confirmed the pharm Dilacor in stock and the Phos Lo Gel Cap interview revealed the abox of thirty count Interview on August private dining room, the back-up pharma failed to provide the the physician from a through the discharg Lo Gel Caps, Loniter Interview on August private dining room, the back-up pharma failed to provide the the physician from a through the discharg Lo Gel Caps, Loniter	t 28, 2013, at 8:20 a.m., with or of Nursing (ADON), in the firmed the Medication ord (MAR) with circled he medication had not been er interview confirmed the witheir policy to document the e to administer the  28, 2013, at 8:40 a.m., by the pharmacy pharmacist, sent the physician orders to wril 12, 2013. Further interview had crossed out the Phos Loutapres was not completely sed out on the document macy. Further interview en and Dilacor were not in led to the facility. Further the facility sent another in April 13, 2013, for Phos Lound Dilacor. Further interview had provide the facility with ps on April 13, 2013. Further the pharmacy could not break of Catapres.  29, 2013, at 10:09 a.m. in the with the ADON, confirmed cy and the main pharmacy medication as prescribed by dmission, on April 12, 2013, je, on April 16, 2013, for Phos in, Catapres and Dilacor.	F 4:				
	483.60(c) DRUG RE IRREGULAR, ACT (	GIMEN REVIEW, REPORT ON	F 42	8			

PRINTED: 09/04/2013 FORM APPROVED OMB NO 0038-0301

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) AP 5 770	LE CONSTRUCTION	UND IN	<u>J. U838-U39</u>	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LE CONSTRUCTION		MPLETED	
		445457	B. WING		00	/28/2013	
	PROVIDER OR SUPPLIEF  NNESSEE HEALTH		4	STREET ADDRESS, CITY, STATE, ZIP CO 185 ISBILL RD MADISONVILLE, TN 37354	DE J US	V28/2U13	
(X4) ID PREFIX TAG			SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFENT)				
F 428	reviewed at least of pharmacist.  The pharmacist muthe attending physical pharmacist muther attending physical	age 28  of each resident must be noce a month by a licensed ust report any irregularities to cian, and the director of reports must be acted upon.	F 428	Review, Report Irregular  SS=D  Requirement:  The drug regimen of each must be reviewed at least month by a licensed pharmace.	resident once a cist. The		
	by: Based on medical recommendation refalled to ensure a pupon timely for one residents reviewed. The findings include Resident #20 was a 5, 2006, with diagnostyndrome, insomniwith Agitation.  Medical record reviewed.etcapitulation order revealed "Citalop medication)40 mg(tablet) by mouth at pharmacy recomme 2013, revealed "rdecrease the Citalop decrease the Citalop	ed: admitted to the facility on June oses including Organic Brain a, Dementia, and Psychosis ew of the Physician r's for July (no signed date), ram (antidepressant g (milligrams)one lab bedtime. Review of a andation print date July 30, night be appropriate to		pharmacist must report irregularities to the apphysician and the director of and these reports must be activated.  1. Resident # 20 medication reductive 8/17/2013:  2. An Audit of all Planecommendations completed on 8/28/2 DON.  3. The Director of Phaservices in-services pharmacy consultant 8/29/13 to provide report the facility no more business days from the facility of consultant pharmacy Consultant make every effort to	ttending f nursing ed upon.  received ion on harmacy was 2013 by tarmacy d the tts on ports to than 3 he date The t will		

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING TN6201 08/28/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG (005) COMPLETE DATE ID PREFIX TAG DEFICIENCY F428 these reports electronically i but will also provide a paper copy via intercompany mail delivery. Administrator inserviced DON or designee on 9/16/2013 to contact doctors regarding any reports to be acted upon via fax. phone, or personal delivery. If no response in timely manner, the medical director will be notified to intercede to maintain compliance. 4. Nurse Management monitor monthly 3 months, then quarterly 6 months until substantial compliance achieved. If compliance not met, Administrator will rein-service/educate substantial compliance achieved. Completed By: 09/20/2013 Division of Health Care Facilities (X6) DATE TITLE

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

8|3311

If continuation sheet 1 of 1

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES		F	RINTED: 09/04/20	01
STATEMEN	ERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROV	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
445457			B. WING			
NAME OF	PROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE, ZIP CODE	08/28/2013	
EASTT	ENNESSEE HEALTH C		1 -	465 ISBILL RD MADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ON SHOULD BE COMPLÉTION LE APPROPRIATE DATE	
F 428	celexa (citalopram) (for) 1(one) week an	to 10 mg PO (by mouth)x kd d/c (discontinue)"	F 428			
F 441 SS=E	Director of Nursing ( 11:07 a.m., in the Do pharmacy recommen until eighteen days la	al record review with the DON) on August 28, 2013, at DN office, confirmed the ndation was not acted upon ater.  CONTROL, PREVENT	F 441	<b>F441</b>		
	sale' saultaly and co	gram designed to provide a mfortable environment and evelopment and transmission		483.65 Infection Control, Preve Spread, Linens SS=E	nt	
	Program under which (1) Investigates, control in the facility; (2) Decides what proc should be applied to a	blish an Infection Control it - rols, and prevents infections sedures, such as isolation, in individual resident; and of incidents and corrective		Requirement:  The facility must establish as maintain an Infection Control Program designed to provide a saft sanitary and comfortable environment and to help prevent the development and transmission of the same and tra	ol e, le	
	prevent the spread of solate the resident.  2) The facility must prommunicable diseasmon direct contact with transfer contact will transfer to the contact will be contact will transfer the contact will transfer the contact will transfer the contact will transfer the contact will transfer the contact will transfer the contact will transfer the contact will transfer the contact will transfer the contact will transfer the contact will transfer the contact will transfer the contact will transfer the contact will transfer the contact will be contact will transfer the contact will transfer	control Program dent needs isolation to infection, the facility must chibit employees with a e or infected skin lesions h residents or their food. If	The second secon	disease and infection.  1. Shower room #2 cleane immediately 8/26/2013.  2. Both shower rooms audite on 8/26/2013 to ensure star maintains a sanitary area by Charge Nurses. License	d ff y	

hands after each direct resident contact for which

nurses to audit shower rooms

PRINTED: 09/04/2013 FORM APPROVED

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-036 (X3) DATE SURVEY COMPLETED 08/28/2013	
		IDENTIFICATION NUMBER:				
NAME OF PROVIDER OR SUPPLIER  EAST TENNESSEE HEALTH CARE			4			
EAST TENNESSEE HEALTH CAP  (X4) ID SUMMARY STATE (EACH DEFICIENCY MA REGULATORY OR LSC)  F 441 Continued From page hand washing is indical professional practice.  (c) Linens Personnel must handle transport linens so as to infection.  This REQUIREMENT is by: Based on observation a falled to maintain a sani of two showers.  The findings included: Observation during the in-		rement of deficiencies MUST BE PRECEDED BY FULL CONTIFYING INFORMATION)  De 30  Cated by accepted  Cated by	4	STREET ADDRESS, CITY, STATE, ZIP CODE  465 ISBILL RD  MADISONVILLE, TN 37354  PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)  411  daily during routine to ensure compliance. 3. DON/ADON in-s nursing staff on procedure for in control and removal of material when in room setting and in-set Licensed Nurses for auditing on 8/26 8/30/2013, 9/10/2013 9/16/2013. If any n staff missed the in-set he or she will be in-set during orientation. 4. Interdisciplinary Tean make monitoring roun ensure compliance daily for 30 days and then we for 3 months, then biwe	N (XS) DBE RIATE COMPLETION DATE  Unds  iced oper tion ecal wer ced aily 13, and ing ce, ed ny ed to to	
II A R	rview with the Assistant Director of Nursing on just 27, 2013, at 8:22 a.m., in the conference in, confirmed the Certified Nursing Assistants is to clean up all body fluids at the time of urance.		for 1 month until substantial compliance is achieved. The Infection Control Committee will conduct random rounds to ensure Infection Control Protocol compliance is maintained for six (6) weeks. Findings will be reported in the morning QA meeting. If	al e e c s		

AND PLAN C	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:		(22) MULTIPLE CONSTRUCTION A. BUILDING:	
<del></del>		TN6201	B. WING		08/28/2013
NAME OF PE	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	ITATE, ZIP CODE	
EAST TEN	inessee health c	CARE 465 ISE	HLL RD DNVILLE, TN 3	7284	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	LILD BE COMPLE
			F428	Administrator and N Management will n	met, urse :-in! until
- 1	•	··• •			Completed
1				±-	09/20/201
ĺ				<b>4</b> ∙	
					, [
İ				a):	
					1
					. ]
			I 1		i
					Ì
					· I
			l f	e a	
ļ			<b>.</b>	· •	j
İ				_	
				<u>.</u>	ſ
ļ					1
ļ					
lan adda abb	Care Facilities	<u> </u>		<del> </del>	